TESTIMONY OF

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on
MEDICAID UPPER PAYMENT LIMITS

before the
SENATE FINANCE COMMITTEE

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Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting us to discuss concerns we share regarding States' use of Medicaid upper payment limits. As you know, some States are using the flexibility in setting the maximum rates that can be paid to Medicaid providers -- the so-called upper payment limits -- to obtain Federal matching funds in ways that are inconsistent with the intent of the Medicaid statute. Some States are using these matching funds for worthy purposes, such as supporting public hospitals and other health care programs. While these other programs are laudable, some are not eligible for federal Medicaid funding. In other States, it is unclear what the money is used for, and in some cases it appears to be going for programs that are unrelated to health care.

The HHS Inspector General's findings on this are troubling. In all States engaged in these practices, the Federal funds are being obtained without the statutory State matching contribution, and without the accountability that is essential in all public programs. The five-year cost of this growing State practice is likely to be in the tens of billions of dollars, and there is an influx of new State proposals.

Existing regulations never anticipated these abuses. To end these abuses, we must issue a proposed regulation that will modify the current upper payment limits for non-State public facilities, thereby limiting the accounting maneuvers that have allowed States to questionably obtain federal matching funds. To help States adjust and prevent potential adverse impact on health care programs, there will be adequate transition provisions to phase in the new policy. We will also take into account the need to assure that public hospitals can continue to meet their mission of serving Medicaid and uninsured patients.

The proposed regulation will be open for public comment. And we want to work with States, beneficiary groups, providers, the HHS Inspector General, the General Accounting Office, and this Committee as we proceed to ensure that federal funds are used in accordance with the letter and the intent of the law, and that reasonable accommodations are made to help States adjust to necessary policy corrections.

Background

Under current Federal regulations, States have great flexibility in setting the Medicaid rates that they pay to nursing homes, hospitals, and other providers. These regulations establish that States may pay facilities a total amount up to the level that Medicare would pay for the same services, group facilities together in calculating this upper payment limit (UPL), and pay some facilities more than others. This has allowed States to recognize that some public facilities have higher operating costs due to patient populations that are sicker and more likely to have no health care coverage at all.

However, it appears that some States are:

- calculating the UPL that, in theory, could be paid to each Medicaid facility;
- adding these amounts together to create excessive payment rates to a few county or municipal facilities;
- claiming Federal matching dollars based on these excessive payment rates; and then
- directing these county or municipal facilities to transfer large portions of the excessive payments back to the State government, with many States allowing their county-owned providers to keep less than five percent of the Federal funds that are used to provide these excessive payments.

This is not consistent with the intent of the Medicaid statute that specifies that provider payments must be economic and efficient and for Medicaid-covered services.

The practical outcome is that the States using this financing mechanism actually gain Federal matching payments without any new State financial contribution. In fact, through these practices, it is possible for a State that should receive $1 in federal funds for every State dollar spent on Medicaid to instead receive $5 or more in federal funds for every State dollar spent. In addition, if a State requires county or municipal facilities to refund its own Medicaid contribution, the practice also effectively undermines the requirement that a State share in the funding for its Medicaid program.

Moreover, this practice appears to be creating rapid increases in Federal Medicaid spending, with no commensurate increase in Medicaid coverage, quality, or amount of services provided. There is preliminary evidence that this current practice has contributed to a spike in Federal Medicaid spending. The States' estimates of Federal Medicaid spending for FY 2000 have already increased by $3.4 billion over earlier projections. Assuming additional States come forward with State plan amendments, the five-year cost of this growing State practice can bein the tens of billions of dollars. Currently, 19 States have approved plan amendments and 14 have pending amendments (for a total of 28 states because some haqe both pending and aproved amendments), This could have the long-term effect of undermining the core mission and the broad-based support for Medicaid, which guarantees critical health services to our most vulnerable populations: low-income children and families, people with disabilities, and the elderly.

The excess Federal Medicaid payments that are shared with State and local governments are put to any number of uses--both health- and non-health-related. It appears some States allow public hospitals to keep a portion of these funds to help pay for uncompensated care. While the Medicaid disproportionate share hospital (DSH) program was created to cover these costs and

now accounts for more than $14 billion annually in total Medicaid spending, the DSH program has not always met the growing challenge of caring for the uninsured. Some States have, through the UPL arrangement, circumvented the statutory DSH limits--using indirect means to accomplish what the DSH statute does not allow.

Other States are using these payments to pay the statutory State share of Medicaid or of the State Children's Health Insurance Program (SCHIP). While Medicaid and SCHIP are Federal/State partnerships in which each partner pays a share established in statute, the UPL arrangements shift a portion of a State's share to the Federal government. The result is that Federal taxpayers in all States are forced to shoulder more than their share for Medicaid and SCHIP in a few States.

Still other States are using the UPL arrangement to finance other health programs beyond Medicaid and SCHIP. This results in Medicaid funding being used for otherwise laudable health care purposes, but for people and/or services not eligible for Medicaid coverage.

Other reports suggest that some States have gone so far as to use -- or intend to use -- the UPL arrangement for non-health purposes.

- Several States appear to have used it to fill budget gaps.
- Another State's local newspaper reported that Federal Medicaid funds would be used for State tax cuts or for reducing State debt.
- One State announced that it intended to use funds generated through the UPL system to pay for education programs.

These practices, which are effectively general revenue sharing, are inconsistent with the Medicaid statute, Congressional intent, and Administration policy. However, we lack authority under existing regulations to deny State proposals to engage in these arrangements. Furthermore, significant public policy should be made through an open public process. The HHS Office of Inspector General and General Accounting Office have both looked into this and are reporting on some of their findings here today.

We sent a letter to States in July describing all these concerns and giving notice of our intention to act to stop this inappropriate use of Federal funding. States and hospitals have, understandably, expressed concern about the impact on other health care programs. We share these concerns, and are committed to both ending inappropriate use of federal funds and establishing appropriate transition provisions to help States adjust to necessary policy changes.

Proposed Regulation

We will shortly issue a proposed regulation to address these concerns. The proposed rule will create some type of separate reimbursement limits for non-State public facilities. States will no longer be able to pool amounts for both private and non-State owned public facilities and claim the total of that pool for federal matching funds. Recognizing higher costs incurred in public hospitals, we will include provisions to ensure adequate reimbursement rates for these facilities.

To help States adjust, we will make a gradual transition to the new policy. Specifically, we anticipate a multi-year transition that would not affect any State with an approved UPL policy in

2001. We will solicit comments on our proposed changes to the UPL policy, as well as the transition provisions, and we are open to other courses of action that will accomplish the same goals set out in the proposed rule.

We understand that change will be difficult--just as it was in the early 1990's when the Federal/State financing relationship had to be re-adjusted because of now illegal State funding mechanisms of donations and taxes. We will specifically solicit comments on proposed transitional periods to address this reliance.

Other Efforts

The Administration is committed to supporting health care providers who serve the uninsured and chronically ill and to assuring that they can continue to do so. The President's budget includes more than $100 billion over 10 years to expand health insurance to the uninsured. These funds would reduce the uncompensated care in public hospitals. It also includes a long-term care initiative and Medicare and Medicaid provider payment restoration initiative that explicitly targets funding to nursing homes and hospitals, which will also help institutions directly. We have urged the Congress to pass this initiative this year.

CONCLUSION

The Medicaid program has been successful over the years in providing vital health care services to millions of low-income Americans. It will continue to be successful only to the extent that it adheres to that mission and ensures that the funds provided are used appropriately and that the program retains its integrity. The program will enjoy public support only if it maintains public trust.

We appreciate the need to proceed with caution in addresing UPL abuses in order to ensure that there is no adverse impact on worthy but now improperly funded health care programs. But we also understand the need to act decisively to ensure that Federal funds are spent in accordance with the law. I thank you for holding this hearing, and I am happy to answer your questions.

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